

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u>		c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Greensboro</u>	
		f. STREET ADDRESS <u>None</u>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/3/1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horatio Adams</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Carmean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gorden Adams</u>		Address <u>Greensboro, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Myocarditis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 4, 1957</u> to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 31, 1959</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>8-1-59</u>			
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair</u>		ADDRESS <u>Greensboro Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

7751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural		c. LENGTH OF STAY IN 1b 55 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edith Gertrude Adams		4. DATE OF DEATH Month Day Year July 4, 1959	
5. SEX fem.	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James White		14. MOTHER'S MAIDEN NAME Eliza Edgell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Neal Heller		Address Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Osteoarthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Manth, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1959 to July 4, 1959 , that I last saw the deceased alive on July 4, 1959 , and that death occurred at 4:10 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Anderson		DATE SIGNED 7/6/59	
PHYSICIAN'S NAME (Type) Frank M. Anderson			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF July 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery	22d. LOCATION (City, town, or county) (State) Federalsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry Williams		24. REC'D BY REGISTRAR DATE JUL 9 '59	
ADDRESS Federalsburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

IN SENATE, FEBRUARY 1, 1951.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE, 1950.

AND A REPORT ON THE LANDS OF THE STATE, 1950.

BY THE COMMISSIONER OF THE GENERAL LAND OFFICE.

Printed by the State Printer, Austin, Texas.

1951

7761

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg R.F.D.</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Federalsburg R.F.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Reliance Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <u>Rebecca</u> <u>Byrd</u>				4. DATE OF DEATH <u>July</u> <u>9</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1976</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levi S. Byrd</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances McLeod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mrs. Willard Sparklin, Federalsburg, Md. R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular-Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1958 ?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19</u> , 19 <u>59</u> , to <u>July 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>59</u> , and that death occurred at <u>7:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>122 W. Central Ave.</u> DATE SIGNED <u>7/10/59</u> ACTUAL SIGNATURE <u>W. E. Lennon</u> M.D. <u>122 W. Central Ave.</u> <u>7/10/59</u> PHYSICIAN'S NAME (Type) <u>William E. Lennon, M. D.</u> <u>Federalsburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodbine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisonburg, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				24c. REGISTRAR'S NAME <u> </u>			

death. Page 4

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CERTIFICATE OF DEATH

7761

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7752

CERTIFICATE OF DEATH

07738

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CAROLINE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RIDGELY</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>SUE</u> (Middle) <u>ELLA</u> (Last) <u>CHERRY</u>				<u>JULY 6, 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>DEC. 2, 1879</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Corner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>not</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mr. Geo. D. Cherry Ridgely</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>left heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) <u>Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1959</u> to <u>July 4, 1959</u> that I last saw the deceased <u>alive on July 4, 1959</u> and that death occurred at <u>10:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Winwood</u> M.D.				ADDRESS (Street, city, town, state) <u>Ridgely, Md</u>		DATE SIGNED <u>7/7/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 9, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Greenboro</u>		LOCATION (City, town, or county) (State) <u>Greenboro, Md</u>	
24. REC'D BY REGISTRAR <u>JUL 14 '59</u>		REGISTRAR'S SIGNATURE <u>Charles H. Winwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hughmonston, Pastor, Md</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07739

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jenton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>EARLE</u> Middle <u>COLLINS</u> Last		4. DATE OF DEATH <u>July 17, 1959</u> Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 17, 1948</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Marguerite Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Marguerite South, Jenton</u>		Address <u>Jenton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning accident</u> <u>929.8</u> DUE TO <u>Fell from bridge</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from bridge while fishing (Choptank)</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>7-17-59</u> Hour <u>—</u> a.m. <u>—</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Choptank</u>		20f. (City or town) <u>Jenton</u> (County) <u>Caroline</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson D. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAWSON D. GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-17-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jenton</u>		22d. LOCATION (City, town, or county) <u>Jenton</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Moore South, Jenton</u>		ADDRESS <u>Jenton</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JUL 23 '59</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7754

CERTIFICATE OF DEATH

Reg. Dist. No.

07740

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON - RURAL</u>		c. LENGTH OF STAY IN 1b <u>70 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NEAR BETHLEHEM</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE LOUVERA DOWLER</u>		4. DATE OF DEATH Month Day Year <u>JULY 29 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 2, 1876</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>82 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WESTERNPORT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID BURKELEW</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA TRENUM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS. JOHN T. BAYNARD, PRESTON, MD. R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u> <u>20 yrs</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>59</u> , to <u>7/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>59</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lacey B. Plummer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>PRESTON, MARYLAND 7-30-59</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD B. PLUMMER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 1, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JUNIOR ORDER CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NEAR PRESTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. FRAMPTON + SON, FEDERALSBURG, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 31 1959</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u>	

MEDICAL CERTIFICATION

TO DEPUTY CHIEF EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07741

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Tanyard				e. STREET ADDRESS Near Tanyard		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle Lee Last Engle				4. DATE OF DEATH Month July Day 6 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1946		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 15 Days 15	IF UNDER 24 HRS. Hours 15 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public School Student		10b. KIND OF BUSINESS OR INDUSTRY in Preston, Md.		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Wilber Engle				14. MOTHER'S MAIDEN NAME Ethel Quidas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Wilber Engle, Preston, Maryland, RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 824X DUE TO Fractured Neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured Neck DUE TO (c) Fractured Neck PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						INTERVAL BETWEEN ONSET AND DEATH immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from Truck -					
20c. TIME OF INJURY Month, Day, Year 7-6 1959 Hour 8 o. m. 7-6 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Rural Preston Caroline 7-8-59	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-8-59	
EXAMINER'S NAME (Type) DAWSON O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		22d. LOCATION (City, town, or county) (State) Near Preston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF MARYLAND - BALTIMORE 15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

7756 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07742
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feddersburg				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 West Central Avenue				e. STREET ADDRESS 319 West Central Avenue			
3. NAME OF DECEASED (Type or print) First Lena Middle Zahniser Last Hammond				4. DATE OF DEATH Month July Day 25 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1877	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Coulbourne				14. MOTHER'S MAIDEN NAME Anna Marie Todd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Fred Lankford, Feddersburg, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Abdominal aneurysm DUE TO (b) Arterio sclerotic cardiovascular disease DUE TO (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Seaford Delaware				(County)		(State)	
21. I certify that I attended the deceased from 4-4-1955 to 7-25-1959 , that I last saw the deceased alive on 7-23-1959 , and that death occurred at 6:50PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Kingsbury				DATE SIGNED			
PHYSICIAN'S NAME (Type)				ADDRESS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	
22d. LOCATION (City, town, or county) Feddersburg, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Feddersburg, Maryland				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1275

1275

CERTIFICATE OF ANALYSIS

ASBESTOS

ANALYSIS OF
SAMPLE NO. 1275
DATE OF ANALYSIS
ANALYST
FINDINGS
REMARKS

ANALYSIS OF
SAMPLE NO. 1275
DATE OF ANALYSIS
ANALYST
FINDINGS
REMARKS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

7757

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07743

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CAROLINE</u>		STATE <u>Md.</u> COUNTY <u>2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		TOWN <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		STREET ADDRESS <u>3701-47</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JENNIE</u>		(Middle)		(Last) <u>MAYTIN</u>		(Month) (Day) (Year) <u>JULY 31, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>APR. 10, 1885</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MORRIS KASKAWITS</u>				14. MOTHER'S MAIDEN NAME <u>MIRIAM [unknown]</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Dr. Herbert Maytin, Denton Md.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Insufficiency</u>						<u>Probably 5 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.		M.					
22. I hereby certify that I attended the deceased from <u>July 31, 1959</u> , to <u>Aug 31, 1959</u> , that I last saw the deceased alive on <u>Aug 31, 1959</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Paul Kuths</u>				ADDRESS (Street, city, town, state) <u>Denton Md.</u> DATE SIGNED <u>7-31-59</u>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 2, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Helicon</u>		LOCATION (City, town, or county) (State) <u>Queens N.Y.</u>	
24. REC'D BY REGISTRAR <u>John S. [unclear]</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Moore & Son, Denton Md.</u>		ADDRESS	
DATE <u>AUG 4 '59</u>							

CERTIFICATE OF DEATH

Reg. Off. No.

1. PLACE OF DEATH

MARYLAND

COUNTY

CITY

STREET

APARTMENT

ROOM

ZIP CODE

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Tobacco Used

Other Habits

Signature of Physician

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Burial Director

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Cremation

Signature of Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

7758 MEDICAL STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No. 07744

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>GERALD EUGENE MCGHEE</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1944</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard T. McGhee</u>		14. MOTHER'S MAIDEN NAME <u>Frances Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>	
17. INFORMANT <u>Mrs. Frances Butler, Denton, Md.</u>		Address <u>Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning accident</u> <u>929.8</u> DUE TO <u>Fell from bridge</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fell from bridge</u> DUE TO (c) <u>Fell from bridge</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Few weeks</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from bridge while fishing (Choptank River)</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-17 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Benton Bridge</u>	20f. (City or town) <u>Benton</u> (County) <u>Caroline</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u>		DATE SIGNED <u>7-17-59</u>	
EXAMINER'S NAME (Type) <u>DAWSON O. GEORGE</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) <u>Denton, Md.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Moore</u> ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO DEPUTY REGISTRAR: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1171

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Race		5. Date of Death		6. Time of Death		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Examiner		11. Signature of Coroner		12. Signature of Physician		13. Signature of Medical Examiner		14. Signature of Medical Examiner		15. Signature of Medical Examiner		16. Signature of Medical Examiner		17. Signature of Medical Examiner		18. Signature of Medical Examiner		19. Signature of Medical Examiner		20. Signature of Medical Examiner		21. Signature of Medical Examiner		22. Signature of Medical Examiner		23. Signature of Medical Examiner		24. Signature of Medical Examiner		25. Signature of Medical Examiner		26. Signature of Medical Examiner		27. Signature of Medical Examiner		28. Signature of Medical Examiner		29. Signature of Medical Examiner		30. Signature of Medical Examiner		31. Signature of Medical Examiner		32. Signature of Medical Examiner		33. Signature of Medical Examiner		34. Signature of Medical Examiner		35. Signature of Medical Examiner		36. Signature of Medical Examiner		37. Signature of Medical Examiner		38. Signature of Medical Examiner		39. Signature of Medical Examiner		40. Signature of Medical Examiner		41. Signature of Medical Examiner		42. Signature of Medical Examiner		43. Signature of Medical Examiner		44. Signature of Medical Examiner		45. Signature of Medical Examiner		46. Signature of Medical Examiner		47. Signature of Medical Examiner		48. Signature of Medical Examiner		49. Signature of Medical Examiner		50. Signature of Medical Examiner		51. Signature of Medical Examiner		52. Signature of Medical Examiner		53. Signature of Medical Examiner		54. Signature of Medical Examiner		55. Signature of Medical Examiner		56. Signature of Medical Examiner		57. Signature of Medical Examiner		58. Signature of Medical Examiner		59. Signature of Medical Examiner		60. Signature of Medical Examiner		61. Signature of Medical Examiner		62. Signature of Medical Examiner		63. Signature of Medical Examiner		64. Signature of Medical Examiner		65. Signature of Medical Examiner		66. Signature of Medical Examiner		67. Signature of Medical Examiner		68. Signature of Medical Examiner		69. Signature of Medical Examiner		70. Signature of Medical Examiner		71. Signature of Medical Examiner		72. Signature of Medical Examiner		73. Signature of Medical Examiner		74. Signature of Medical Examiner		75. Signature of Medical Examiner		76. Signature of Medical Examiner		77. Signature of Medical Examiner		78. Signature of Medical Examiner		79. Signature of Medical Examiner		80. Signature of Medical Examiner		81. Signature of Medical Examiner		82. Signature of Medical Examiner		83. Signature of Medical Examiner		84. Signature of Medical Examiner		85. Signature of Medical Examiner		86. Signature of Medical Examiner		87. Signature of Medical Examiner		88. Signature of Medical Examiner		89. Signature of Medical Examiner		90. Signature of Medical Examiner		91. Signature of Medical Examiner		92. Signature of Medical Examiner		93. Signature of Medical Examiner		94. Signature of Medical Examiner		95. Signature of Medical Examiner		96. Signature of Medical Examiner		97. Signature of Medical Examiner		98. Signature of Medical Examiner		99. Signature of Medical Examiner		100. Signature of Medical Examiner	
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1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7759

CERTIFICATE OF DEATH

07745

Item 1 FilmG245 7-29-59 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Greensboro</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>1</u>		OR TOWN <u>Bridgely</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Collins Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>MELISSA</u> (First) <u>MITCHELL</u> (Middle) (Last)				4. DATE OF DEATH <u>July 18, 1959</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb 24, 1867</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham D. Twiler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Culp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Henry Twiler Denton, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Dis.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Peripheral arterial occlusion (arteriosclerotic, bilateral)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 6, 1959</u> to <u>July 18, 1959</u> , that I last saw the deceased alive on <u>July 18, 1959</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Streesiepe</u> M.D.				ADDRESS (Street, city, town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>7-18-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 21, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro Md</u>	
24. REC'D BY REGISTRAR <u>JUL 23 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Twiler</u>		ADDRESS <u>Denton</u>	

7760

CERTIFICATE OF DEATH

Reg. Dist. No.

07746

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson		c. LENGTH OF STAY IN lb 6 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Estelle		4. DATE OF DEATH Month July Day 28 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1900	
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Karpenski		14. MOTHER'S MAIDEN NAME Eva Ochinkuska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Joseph Ruggerone		Address 85-43 66Th. Rd. Rego Park, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the pelvic structures, mesenteric lymph nodes & Liver DUE TO (b) Carcinoma of the Cervix DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26 , 19 59 , to July 28 , 19 59 , that I last saw the deceased alive on July 28 , 19 59 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 7-30-59			
ACTUAL SIGNATURE Charles H. Stonesifer M.D.		PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Near Greensboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulton		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR DATE AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

7580

40150

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1955		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY Hypertension, Atherosclerosis	
10. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		11. SIGNATURE OF REGISTRAR J. H. Smith		12. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF BIRTH April 15, 1890		15. OCCUPATION Teacher	
16. MARITAL STATUS Married		17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESSES Hypertension, Atherosclerosis		20. MEDICATION None		21. ALCOHOLIC BEVERAGE None	
22. TOBACCO None		23. DRUGS None		24. OTHER None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF NEXT OF KIN None		27. SIGNATURE OF WITNESSES None	
28. SIGNATURE OF PHYSICIAN None		29. SIGNATURE OF REGISTRAR None		30. SIGNATURE OF WITNESSES None	